

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 64 33781

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDGAR LEMUEL Amoss			2a. DATE OF DEATH MONTH DAY YEAR 12 30 84			2b. HOUR PM 10.10			
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 10 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture	
13a. STATE md				13b. COUNTY Howard		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. ZIP CODE 21210	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar L. Amoss				15. MOTHER'S MAIDEN NAME MIDDLE LAST Ida O. Baines					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-36-7981		17. INFORMANT Katherine Amoss			
				ADDRESS 13210 Bushy Park Rd. Woodbine, Md 21797					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE, VENTRICULAR DUE TO, OR AS A CONSEQUENCE OF TACHYCARDIA (b) SEPTIC SHOCK, GLOBAL ANOXIA DUE TO, OR AS A CONSEQUENCE OF (c) URINARY TRACT INFECTION								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-99, 1984, to 12-31, 1984, that (I) (we) lost saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Krishna P. Kumar				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-31-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHNA P. KUMAR				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-2-85		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard MD		
24. FUNERAL DIRECTOR NAME Slack Funeral Home				25a. DATE REC'D. BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

33788

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Carrie MAY Archer.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/14/84</b>			2b. HOUR <b>2:35 PM</b>			
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 10 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>HEGHS</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE S. LOWE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HARRIET GARDNER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>BA 20 8418</b>		17. INFORMANT <b>FAMILY RECORDS</b>			ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiogenic Shock**

DUE TO, OR AS A CONSEQUENCE OF

(b)

**acute myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION  
**N/A**

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNPREDICTABLE ☐  
OR CONTRIBUTING TO CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
**N/A**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED  
AT WORK ☐ AT HOME ☒21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from **November 84** to **12/14** 19 **84**, that (I) (we) last saw the deceased alive on **12/14** 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.22b. SIGNATURE  
**William Flowers MD**

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

**12/14/84**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

**William Flowers MD**

22e. ADDRESS

**10902 Hickory Ridge Rd Columbia MD**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) **BURIAL**

23b. DATE

**DEC. 17, 1984**

23c. NAME OF CEMETERY OR CREMATORY

**PARKWOOD CSM.**23d. LOCATION  
CITY OR TOWN**PARKVILLE BALTO MARYLAND**

24. FUNERAL DIRECTOR

NAME

**EVANS CHAPEL OF MEMORIES HARFORD**

ADDRESS

**8800 RO.**

25a. DATE REC'D. BY REGISTRAR

**DEC 24 1984**

25b. REGISTRAR'S SIGNATURE

**[Signature]**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

WINTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.)

Item 4 per phone 12/20/84 dad

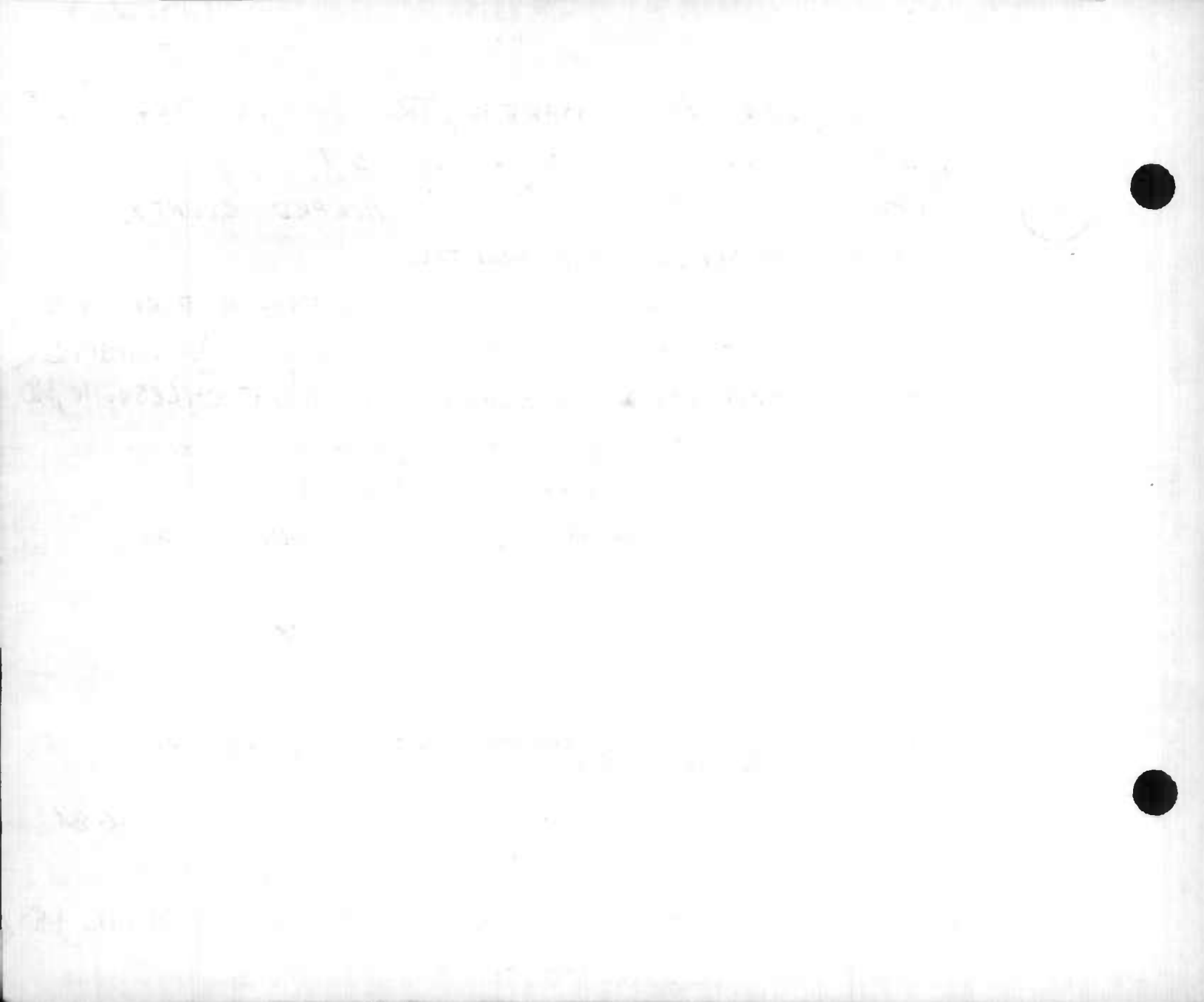
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

33 / 89

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
CHARLES A. BAKER, JR.			12 16 84			5:32 P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE	Caucasian	7 2 17	67 YRS			MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
VA.	USA		HOWARD COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
COLUMBIA	HOWARD CTY GEN. HOSPITAL							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
MD.	CARROLL	SYKESSVILLE	YES <input type="checkbox"/> NO <input type="checkbox"/>			1134 TAYLOR PARK RD 21784		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Charles A. Baker, Sr.			Effie May Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
YES			WWII 212-12-6848			Gladys May Baker Sykesville, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-21</u> 19 <u>84</u> , to <u>12-16</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-16</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
			<u>Louis Solomon</u> MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12-16-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
<u>Louis Solomon</u>			<u>Howard County Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		12/20/84		Crestflawn		Mamotsville, Howard County, MD		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS			DEC 18 1984			<u>John Davidson - Wendell</u>		
<u>Harry W. Haight</u> Sykesville, MD								

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33790 74pm  
REC. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR OF DEATH							
Mary Mariom Bassett								12-6-84		19		84		1914		7:14 PM							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR							
F	W	9-11-09		75 YRS.						12-6-84		19		84		7:14 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																	
Washington D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Howard County MD.																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Columbia		Howard County Hospital		Domestic		Private Home																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Maryland		Howard Co.		Fulton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20759		7417 Cherry Tree Dr													
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
FIRST				MIDDLE				LAST				FIRST				MIDDLE				LAST			
Jacob Bassett												Elizabeth Yardgi											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
No				578 05 1741 M				Harry Bassett				7417 Cherry Tree Drive Fulton, Md. 20759											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED															
Thomas F. Herbert				M.D. Deputy				MEDICAL EXAMINER				12-6-84											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Thomas F. Herbert, MD				Ellicott City Md 21043																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				12/10/84				Fort Lincoln Cemetery				Brentwood P.C. Maryland											
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Francis Gasch's Sons				4739 Baltimore Avenue				DEC 14 1984				Hyattsville, Md. 20781											

Private Note

Private Note

Private Note

Private Note

Private Note





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 3 7 9 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

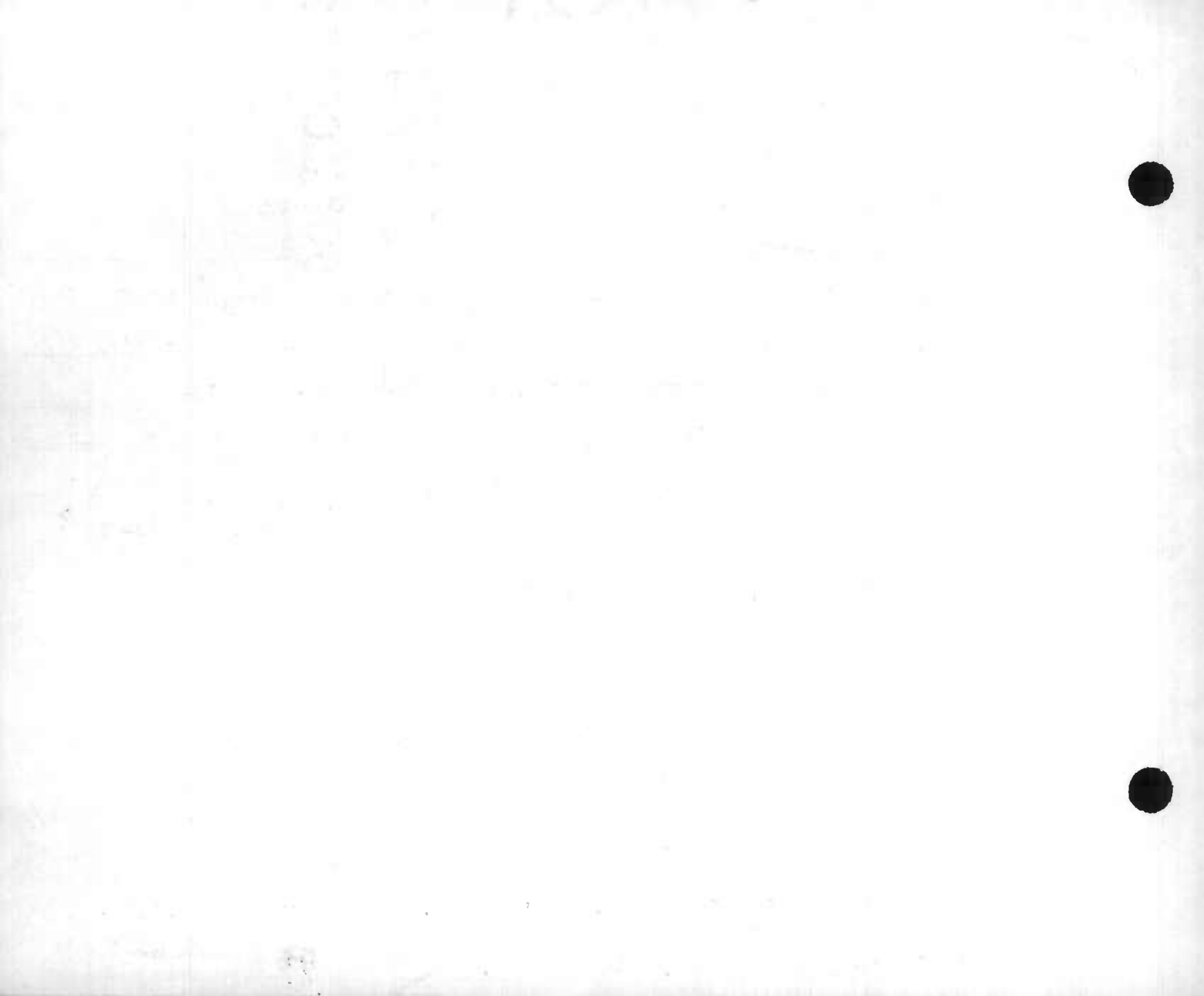
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Anna Mae Beck</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 28 84</b>			2b. HOUR <b>2 P. M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 17 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>md</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John S. Cowan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula -- Collins</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>No</b>		17. INFORMANT ADDRESS <b>Charles Beck Same as #13e</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>metabolic abnormalities</b>		<b>hours</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>pneumonia, cerebrovasc. accident, possible sepsis, renal failure, liver failure</b>		<b>days - ?</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  
**diabetes, pneumonia, cardiac disease**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> 19 <b>84</b> to <b>12/28</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Valentino</b>		DEGREE <b>CARDIOLOGY CONSULTANT</b>		22c. DATE SIGNED <b>12/28/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN A VALENTINO</b>		22e. ADDRESS <b>Howard County General Hospital</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/31/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Nat'l. Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>FLECK FUNERAL HOME INC.</b> NAME ADDRESS <b>7601 Sandy Spring Rd. Laurel, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 2 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

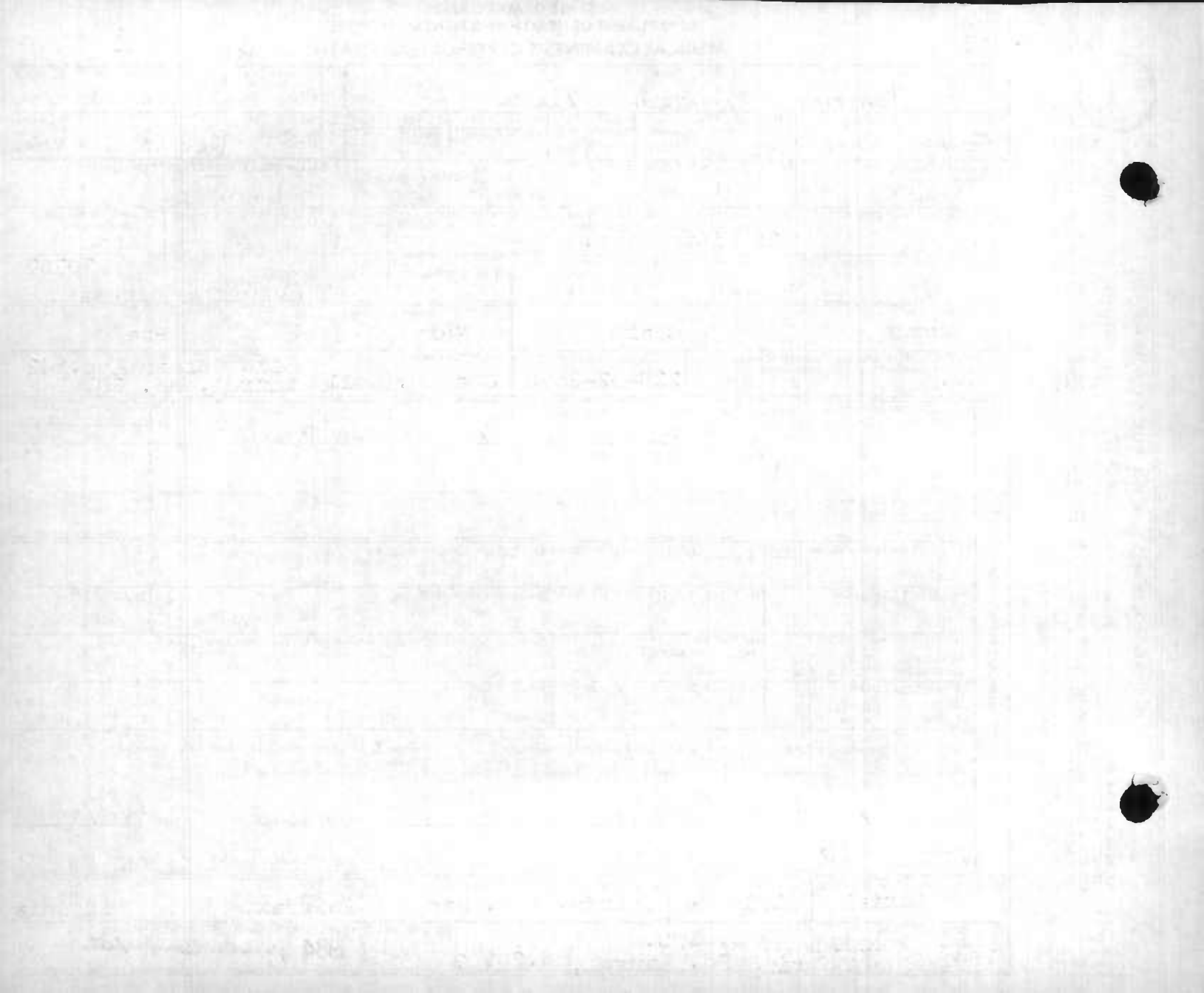
BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
FOR  
1- STATE REGISTRAR  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33. NO. 92

1. DECEASED NAME (TYPE OR PRINT) <b>BEATRICE ELIZABETH BLANCH</b>			7a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>Dec 15 1984</b>			2b. HOUR <input type="checkbox"/> M						
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 13 1911</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>73 YRS.</b>		7c. DATE PRONOUNCED DEAD <b>Dec 15 1984</b>		2d. HOUR <b>938A</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b>			
10. CITY OR TOWN OF DEATH <b>LAUREL</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>25 Midway Ave.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE <b>MD</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>LAUREL</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>25 MIDWAY AVE LAUREL</b>		20707		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Clark</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Brady</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No.</b>				16b. SOCIAL SECURITY NO. <b>229-32-8596</b>				17. INFORMANT <b>Joan M. Holly</b> ADDRESS <b>8114 Gorman Ave. 142 Laurel, Md. 20707</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Bert F. Morton</b>				TITLE (SPECIFY) _____				DATE SIGNED <b>12/15/84</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>BERT F. MORTON</b>				ADDRESS <b>2802 Montclair Dr Ellicott City Mo</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/18/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairfax Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fairfax, Virginia</b>				
24. FUNERAL DIRECTOR <b>FLECK FUNERAL HOME, INC.</b> <b>7601 Sandy Spring Rd. Laurel, Md. 20707</b>								25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 3 7 9 3

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary C Bresnan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 02, 1984</b>		2b. HOUR <b>12<sup>50</sup> AM</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 31 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Mfg.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>				13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <b>7080 Cradel Rock Way 21090</b>			

14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Berneburg</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Cowan</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-28-8936</b>	
17. INFORMANT <b>Mr. Timothy Bresnan</b>		ADDRESS <b>1113 Oakland Terrace Rd. 21227</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/2</b> 19 <b>84</b> to <b>12/2</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Harold E. Cook III</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/2/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold Cook III</b>		22e. ADDRESS <b>Howard County General Hospital</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/5/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Howard Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>AM BROSE FUNERAL HOME</b>		ADDRESS <b>1328 S. GAITHER RD. JARVIS 21227</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson Handell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 3 7 9 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Gladys R. Bromwich</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>4</b> YEAR <b>84</b>		2b. HOUR <b>9:00 A</b> M
3. SEX <b>female</b>	4. RACE <b>caucasian</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>11</b> YEAR <b>10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Canada</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Columbia</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>6102 Camelback Lane 21045</b>	
14. FATHER'S NAME FIRST <b>C.</b> MIDDLE <b>S.</b> LAST <b>Bryant</b>		15. MOTHER'S MAIDEN NAME FIRST <b>unknown</b> MIDDLE <b>unknown</b> LAST <b>unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>081 03 5653D</b>		17. INFORMANT ADDRESS <b>6102 Camelback Lane</b> <b>Mrs. Elizabeth Crader Columbia, Md. 21045</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **Chronic Organic Brain Syndrome**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **N/A**

MEDICAL CERTIFICATION

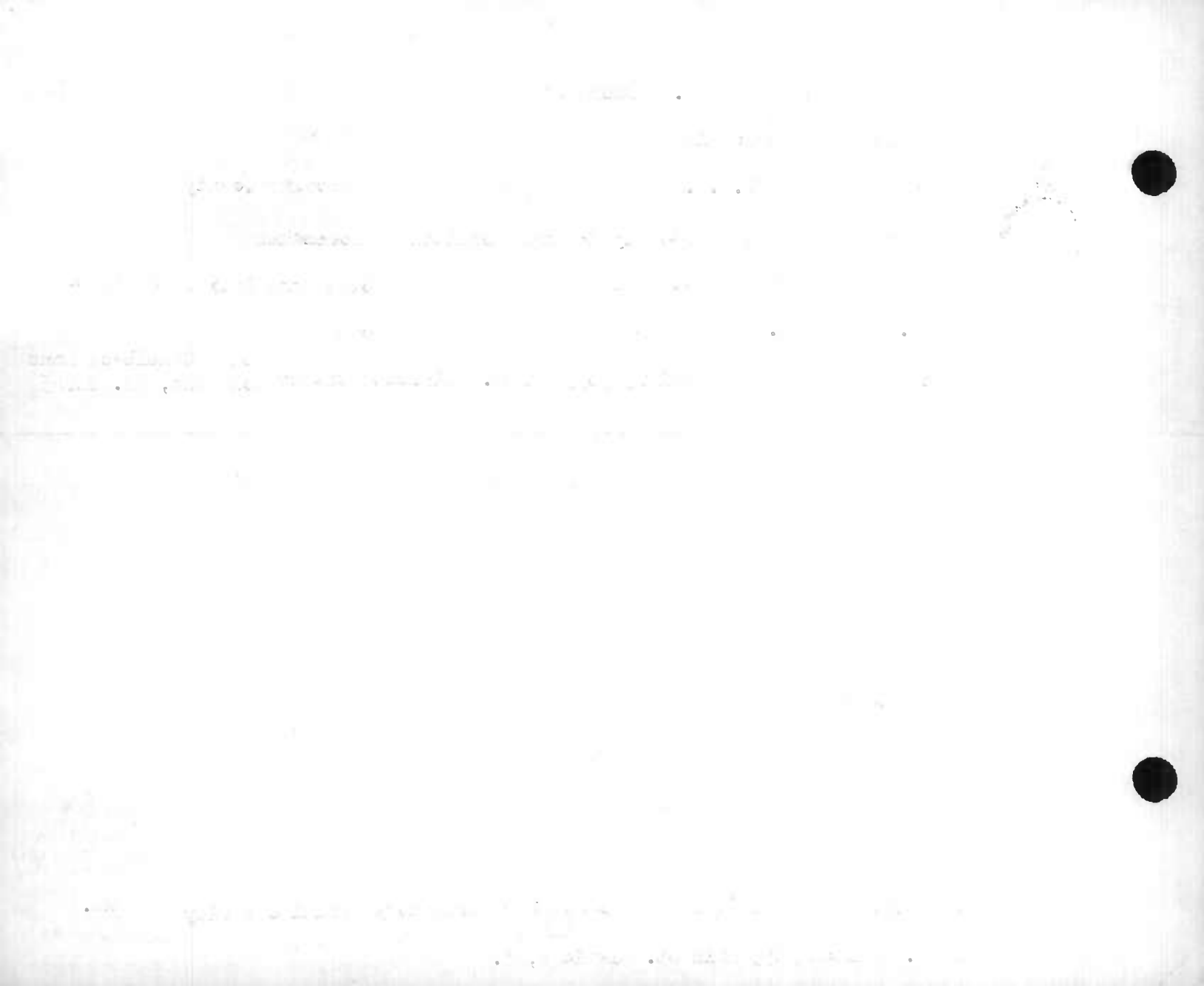
19a. DATE OF OPERATION <b>N/A</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/4</b> , 19 <b>84</b> , to <b>12/4</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>12/4</b> , 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>William Flowers M.D.</b>		22c. DATE SIGNED <b>12/4/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Flowers M.D.</b>		22e. ADDRESS <b>10802 Hickory Ridge Rd Columbia Md 21044</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>	23b. DATE <b>12/6/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Md.</b>
24. FUNERAL DIRECTOR NAME <b>Gary L. Kaufman 5695 Main St. Elkridge, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1984</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5878.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

F

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH3 3 1 9 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
Robert		E.		Coleman		12-27-84				7:24 PM					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				7d. HOUR	
m	B	12 22 15		69 YRS.						12-27-84				7:20 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		USA		X				Howard							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY									
Columbia		Ho. Cty. Gen. Hosp ER		Retired											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD		Howard		Jessup		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9899 Guilford Rd.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
JACOB		A. COLEMAN		SARAH		E. MOORE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO		219-01-7866		M. Engle		Ho Cty. Gen. Hosp.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.															
(b) <u>Chronic myocardial disease</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Thomas F. Herbert				M.D. Deputy				MEDICAL EXAMINER				12-27-84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Thomas F. Herbert MD				Ellicott City MD				21043							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL				1-3-85				Guilford MEM. PARK				Columbia Howard Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
NAME				ADDRESS											
GEORGE R. SNOWDEN				246 N. WASH. ST. ROCKVILLE, MD				AN 4 1985				John Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

33796  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WINIFRED NILAND CROWIN</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>3</b> YEAR <b>84</b>			2b. HOUR <b>5:10</b> P.M.					
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>11</b> YEAR <b>1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 1 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CONNECTICUT</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GEN. HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINE OPERATOR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>AMER. BRASS CO.</b>		
13a. STATE <b>CONNECTICUT</b>				11b. COUNTY <b>New Haven</b>		13c. CITY OR TOWN <b>Waterbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>290 Robbins St. Ct. 06708</b>	
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>NILAND</b> LAST <b>NILAND</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MARGARET</b> MIDDLE <b>BRUNNAN</b> LAST <b>BRUNNAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>044-01-6284</b>		17. INFORMANT NAME <b>Ms Peg Martin</b> ADDRESS <b>6247 Platted Reed Columbia, Md 21044</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b>										YRS	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) <b>10.84</b> attended the deceased from <b>12.3.84</b> 19 <b>12.3.84</b> to <b>12.3.84</b> 19 <b>12.3.84</b> that (I) <b>10.84</b> saw the deceased alive on <b>12.3.84</b> 19 <b>12.3.84</b> and that in (my) <b>10.84</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>10.84</b> (did) <b>10.84</b> (not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T.A. DADISMAN JR</b>						22c. DATE SIGNED <b>12.3.84</b>			22d. ADDRESS <b>5999 Harpers Farm Rd Columbia MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12-6-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW ST. JOSEPH</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>WATERBURY NEW HAVEN CN</b>			
24. FUNERAL DIRECTOR NAME <b>SLACK FUNERAL HOME</b> ADDRESS <b>Box 268 Ellicott City, Md 21043</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1984</b>			25b. REGISTRAR'S SIGNATURE <b>Jane Davidson</b>		

1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

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DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										33197 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERNON MAXIMILLIAN DUKEHART						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-30-84		2b. HOUR M 3:15P			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-26-1909 75 YRS.		6. AGE (IN YEARS) (LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-30-84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13880 Old Frederick Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. CITY OR TOWN Howard		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13880 Old Frederick Rd. 21784			
14. FATHER'S NAME FIRST MIDDLE LAST Brooks DuKehart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Atkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —		17. INFORMANT Marklene P. Dukehart Sykesville, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:35PM 12-30-84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home(storage shed)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 13880 Old Frederick Rd. Sykesville, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				DATE 12-31-84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-3-85		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard MD			
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville, MD				25a. DATE REC'D. BY REGISTRAR JAN 2 1985			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

33798  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GRACE A DuVALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/19/84</b>		2b. HOUR <b>9:50 AM</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>03 20 02</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD CO</b> MD.		
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Horner</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Owings Mills</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>157 Pittsford Circle 21117</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Late George Wolff</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Late Martha Ellen Lewis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-05-3921</b>		17. INFORMANT ADDRESS <b>Shirley Weitzel 7014 Surrey Dr Pikesville Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/27</b> , 19 <b>84</b> , to <b>12/19</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/27</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gary C. Brackner</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/20/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary C. Brackner</b>		22e. ADDRESS <b>10780 Hickory Ridge Rd Col. Md 21044</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12-20-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Md</b>
24. FUNERAL DIRECTOR NAME <b>Harry H Witke</b>		ADDRESS <b>4112 Columbia Rd, Ellicott City Md</b>		25a. DATE REGISTERED <b>DEC 21 1984</b>	
				REGISTRAR'S SIGNATURE <b>S. Davidson-Pendall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				33799 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Ann C. Falkenberg				2a. DATE OF DEATH MONTH DAY YEAR December 13, 1984				2b. HOUR 6 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. STATE Maryland				13b. COUNTY P.G. Co.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 332 Prince George St. 20707	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Nolton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wladarsky							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.				16b. SOCIAL SECURITY NO. 553-26-2027		17. INFORMANT 16008 Kent Rd. Robert E. Leter Laurel, Md. 20707					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>General Atherosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sec</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alzheimers, cv*</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I (this hospital) attended the deceased from <u>12/13/84</u> to <u>12/13/84</u> , that (I (we) lost saw the deceased alive on above (I (we) did) did not view the body after death.											
22b. SIGNATURE <u>Melvin J. Kordon</u> DEGREE <u>MD</u> 22c. DATE SIGNED <u>12/14/84</u>								22d. ADDRESS <u>2000 Century Plaza</u> <u>Columbia</u> <u>MD 21044</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY Md. National Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G. Co. Md.			
24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707						25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 3 8 0 0  
REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST SUSAN		MIDDLE ELLEN		LAST FAY		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12-2-84		2b. HOUR M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 4 1951		6. AGE (IN YEARS) 33 (BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12-2-84	
7a. BIRTHPLACE (STATE OR COUNTY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County					
10. CITY OR TOWN OF DEATH Elkridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S-195 S of Harbor tunnel Ramp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6967 Three Majors Lane 21045			
14. FATHER'S NAME FIRST William L. Fay MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST Vivian E. Miller MIDDLE LAST				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO, OR UNKNOWN) No			
16a. SOCIAL SECURITY NO. 204 58 6195				17. INFORMANT Vivian Roadarmel				17a. ADDRESS 1531 N. Drexel Rd. Lot 253 West Palm Beach Fla 33409			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:44AM 12-2-84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by an auto			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hgwty.				21f. LOCATION STREET CITY OR TOWN COUNTY STATE S-195 S of Harbor Tunnel Ramp Howard Co., Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 12-2-84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 12/4/84		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL HOME Brazdzinski Funeral Home				25a. DATE REC'D. BY REGISTRAR DEC 4 1984				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 signifies any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 8 4				3 3 8 0 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN EMERSON FEAGA</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12 17 84</b>				2b. HOUR <b>9<sup>20</sup> A.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 14 1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>					
10. CITY OR TOWN OF DEATH <b>MARRIOTTSTVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1265 HENRYTON ROAD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EXCAVATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMP.</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>MARRIOTTSTVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1265 HENRYTON RD. 21104</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>BERNARD K. FEAGA</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA M. POWELL</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES KOREA</b>			
16a. SOCIAL SECURITY NO. <b>215/28/6601</b>				17. INFORMANT <b>MARGARET FEAGA</b>				17. ADDRESS <b>1625 HENRYTON RD. MARRIOTTST.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, GENERALIZED</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF COLON</b>										1 YR	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CORONARY ARTERY DISEASE</b>											
19a. DATE OF OPERATION <b>5/22/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>COLON CARCINOMA</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from <b>5/3</b> , 19 <b>84</b> , to <b>12/17</b> , 19 <b>84</b> , that (b) (we) last saw the deceased alive on <b>12/9</b> , 19 <b>84</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W.E. SIGNOR MD</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/17/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.E. SIGNOR M.D.</b>				22e. ADDRESS <b>3459 ST. JOHNS LA. 21043</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-20-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CRESTLAWN MEM. GDN.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARRIOTTSTVILLE HOWARD MD</b>					
24. FUNERAL DIRECTOR NAME <b>SLACK FUNERAL HOME</b>				ADDRESS <b>BOX 268 ELICOTT CITY MD</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1984</b>		25b. REGISTRAR'S SIGNATURE <b>W. E. Signor</b>			

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John Emerson

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FOR  
1- STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33802

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JESSIE IRENE HARRIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 24 84</b>		2b. HOUR <b>3 (4) M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 6 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>	
10. CITY OR TOWN OF DEATH <b>CLARKSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2081 Hall-Shop Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>CLARKSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2081 Hall-Shop Rd 21029</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JESSIE DOESBY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNE SMITH</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-308653</b>		17. INFORMANT ADDRESS <b>John HARRIS, Sr. (HUSBAND) SAME AS #13</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **RESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **METASTATIC BREAST CANCER**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**DIABETES MELLITUS**

19a. DATE OF OPERATION <b>—</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>11/23</b> 19 <b>84</b> , to <b>11/24</b> 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>11/23</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) saw the body after death.			
22b. SIGNATURE <b>George R. Snowden</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>12/24/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George R. Snowden, MD</b>		22e. ADDRESS <b>5540 TEN OAKS RD. CLARKSVILLE, MD 21029</b>	

23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>12-28-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bushy PARK CEM.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>COOKESVILLE, HOWARD MD.</b>
24. FUNERAL DIRECTOR NAME <b>GEORGE R. SNOWDEN</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>John K. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 33803

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Hallie Mae Hilleary</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Dec. 5 84</b>		2b. HOUR <b>10A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 6 92</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>				
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8822-C Town &amp; Country Blvd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Hecht Co.</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Ellicott City</b> 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lucian Runkles</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Harrison</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>219-30-5067</b>		16c. HOME ADDRESS <b>8822-C Town &amp; Country Blvd. Ellicott City, Md. 21043</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF COLON</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>and CARCINOMA OF PANCREAS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>DEMENTIA, HYPERTENSION</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>9/21 79 death</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/2/84</b> to <b>12/6/84</b> , that (I) (we) saw the deceased alive on <b>12/6/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Albin Kuhn II</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/6/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBIN KUHN II</b>		22e. ADDRESS <b>1001 PINE HOBARTS AVE, BALT, MD 21229</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-8-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Meth. Church Cem-Mt. Airy, Md.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Nat'l. Pike</b>		24. FUNERAL DIRECTOR <b>G. Truman Schwab</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 7 1984</b>		
25b. REGISTRAR'S SIGNATURE <b>G. Truman Schwab</b>		25c. REGISTRAR'S SIGNATURE <b>G. Truman Schwab</b>				

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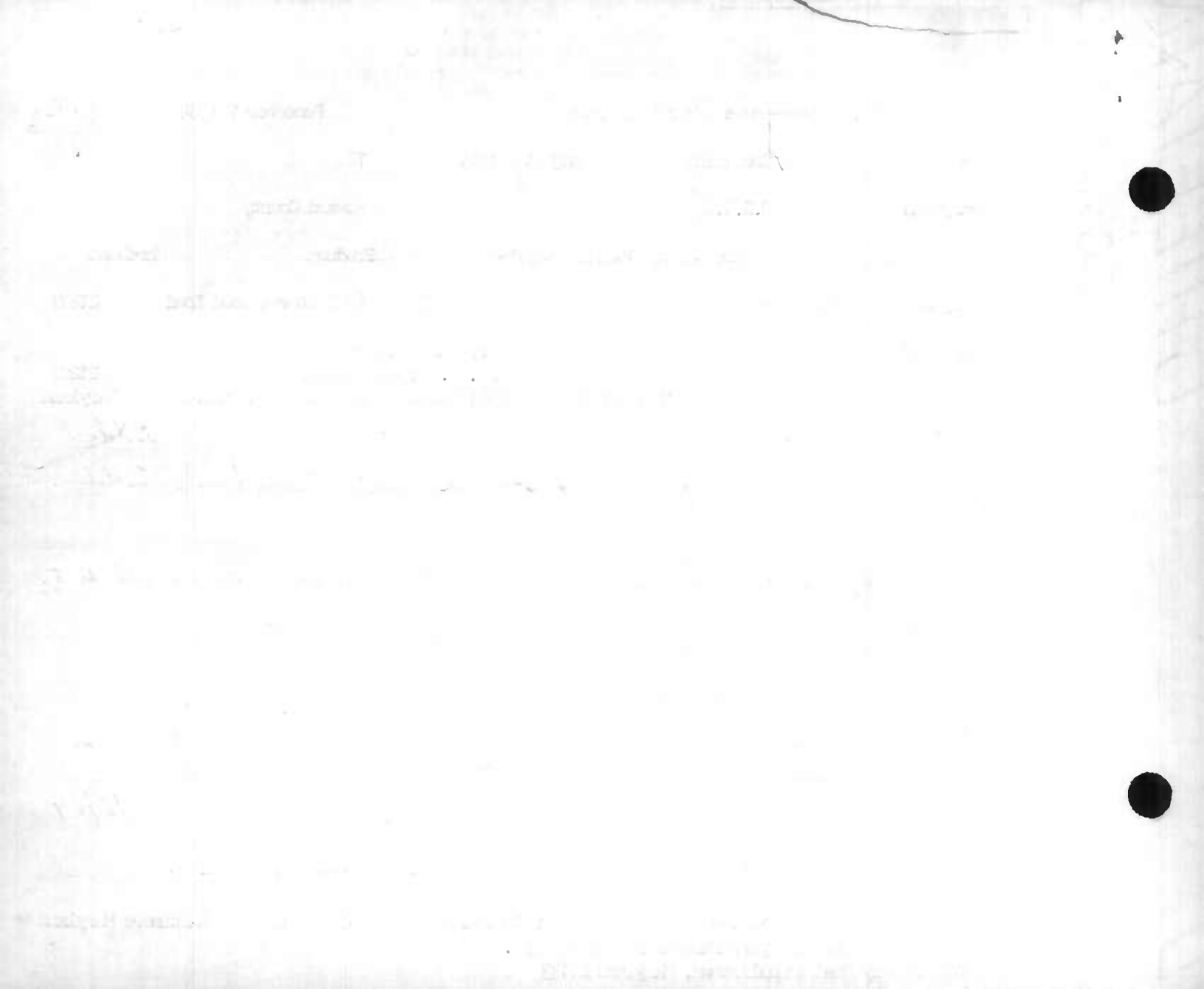
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH33804  
REG. NO.FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mr. Lawrence Ford Horton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 7 1984</b>			2b. HOUR <b>12<sup>15</sup> P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 8 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Produce</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Merchant</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8521 Stevenswood Road 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Ford</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Anna Murphy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-09-7770</b>		17. INFORMANT ADDRESS <b>Mrs. I. Western Horton 21207</b> <b>8521 Stevenswood Road Baltimore Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sudden.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Hypertensive Arteriosclerotic Cardiovascular Disease. He of old M.I.</b>									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER</b> , 19 <b>81</b> , to <b>December 7</b> , 19 <b>84</b> , that <del>we</del> (we) lost saw the deceased alive on <b>December 7</b> , 19 <b>84</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>we</del> (we) (did) <del>not</del> view the body after death. ( <b>HOWARD COUNTY HOSPITAL</b> )									
22b. SIGNATURE <b>Herman Brecher M.D.</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/8/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Herman Brecher</b>				22e. ADDRESS <b>6410 Windsor Mill Rd. 21207</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-10-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 11 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
8728 Liberty Road Randallstown, Maryland 21133									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 33805	
1- STATE REGISTRAR							2a. DATE KNOWN ESTIMATED			2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST							DATE OF DEATH MONTH DAY YEAR			HOUR	
ALBERT JACKEWITZ							12-26 1984			9:40 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD	MONTH DAY YEAR			HOUR	
M	W	9-21-25	59 YRS.			12 26 1984					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Maryland		U.S.A.				Howard County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Columbia		HOWARD COUNTY GENERAL				Salesman		Automobile			
13a. STATE				13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		21043		
MD				HOWARD	ELICOTT CITY	YES <input type="checkbox"/> NO <input type="checkbox"/>	3105		WOODSDALE		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
late Leopold Jackewitz					late Alice Mroz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No			220 14 5703		Mrs Lillian Jackewitz 3105 Normandy Wood					Ellicott City 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.						TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER			DATE SIGNED <u>12-26-84</u>		
EXAMINER'S NAME (TYPE OR PRINT) <u>Thomas F. Herbert, MD</u>						ADDRESS <u>Ellicott City, MD 21043</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			Dec 29'84		Holy Rosary			Baltimore Maryland			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR SIGNATURE		
Harry H Witzke 4112 Columbia Rd Ellicott City						DEC 28 1984			<u>John Davidson-Randall</u>		

90% COTTON FIBRE

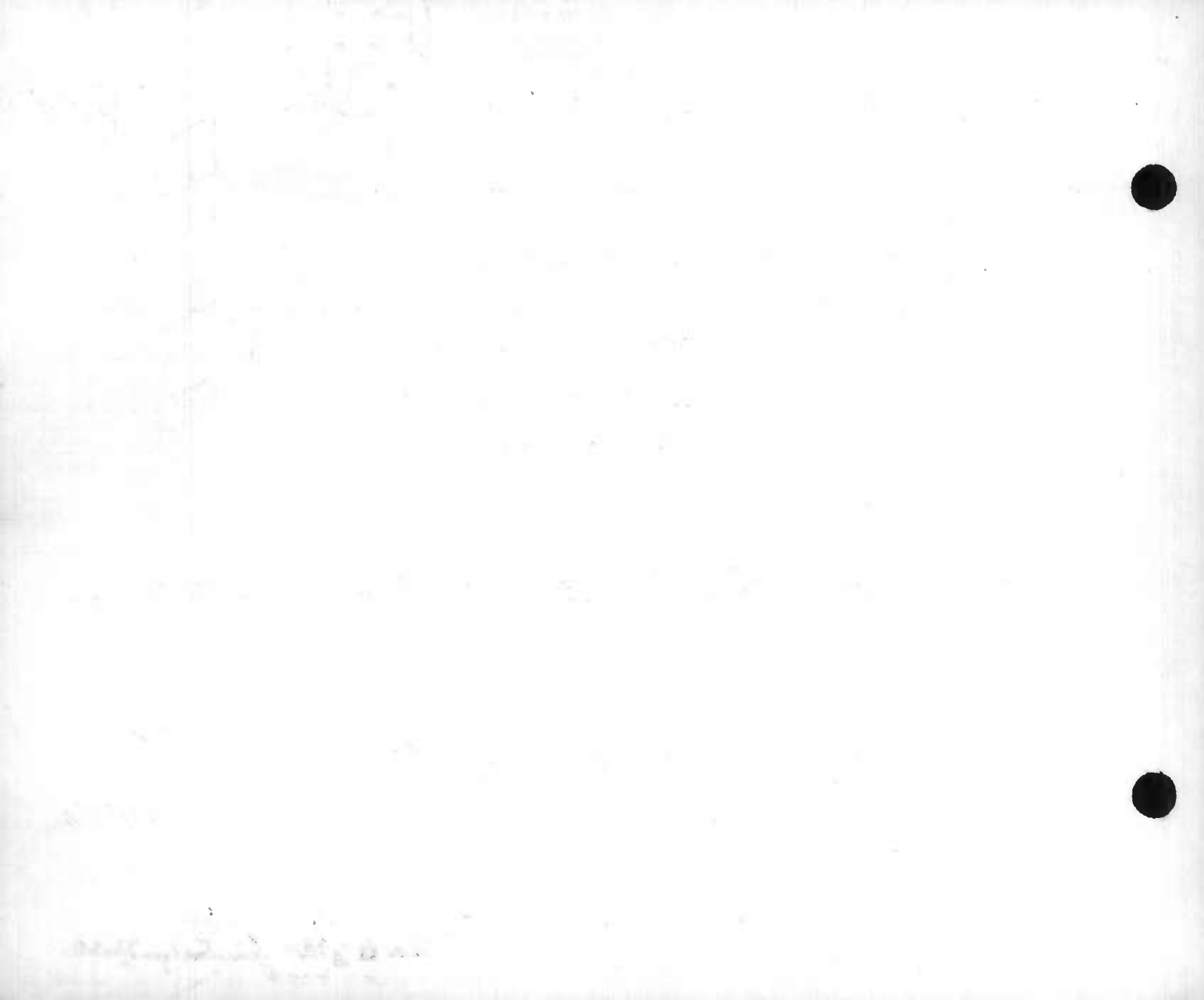
WELFARE BOARD



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH3 3 8 0 6  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GRACE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/3/84</b>			2b. HOUR <b>2:05 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 19, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Fulton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pierpont</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgeanna ?</b>			13e. STREET ADDRESS / ZIP CODE <b>11919 Queen Street 20759</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217 40 2329</b>		17. INFORMANT ADDRESS <b>William Kolpack same as above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>congested heart failure</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/3/84</b> to <b>12/3/84</b> , that (I) (we) last saw the deceased alive on <b>12/3/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. S. SEALS</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/3/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. S. SEALS</b>			22e. ADDRESS <b>Col. 02.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 6, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Lutheran</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fulton, Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Donaldson Funeral Home, Laurel, Md</b>									

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH33807  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Florence J. LaRocca</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/7/84</b>			2b. HOUR <b>4<sup>00</sup></b> M			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 12 26</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>US</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Payroll clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Police</b>	
13a. STATE <b>MD</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Aloysious Moylan</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Frances P Hobbs</b>			13. STREET ADDRESS / ZIP CODE <b>9562 Transfer Row. 31045</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>James A LaRocca 9562 Transfer Row</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Carcinoma of the Lung**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

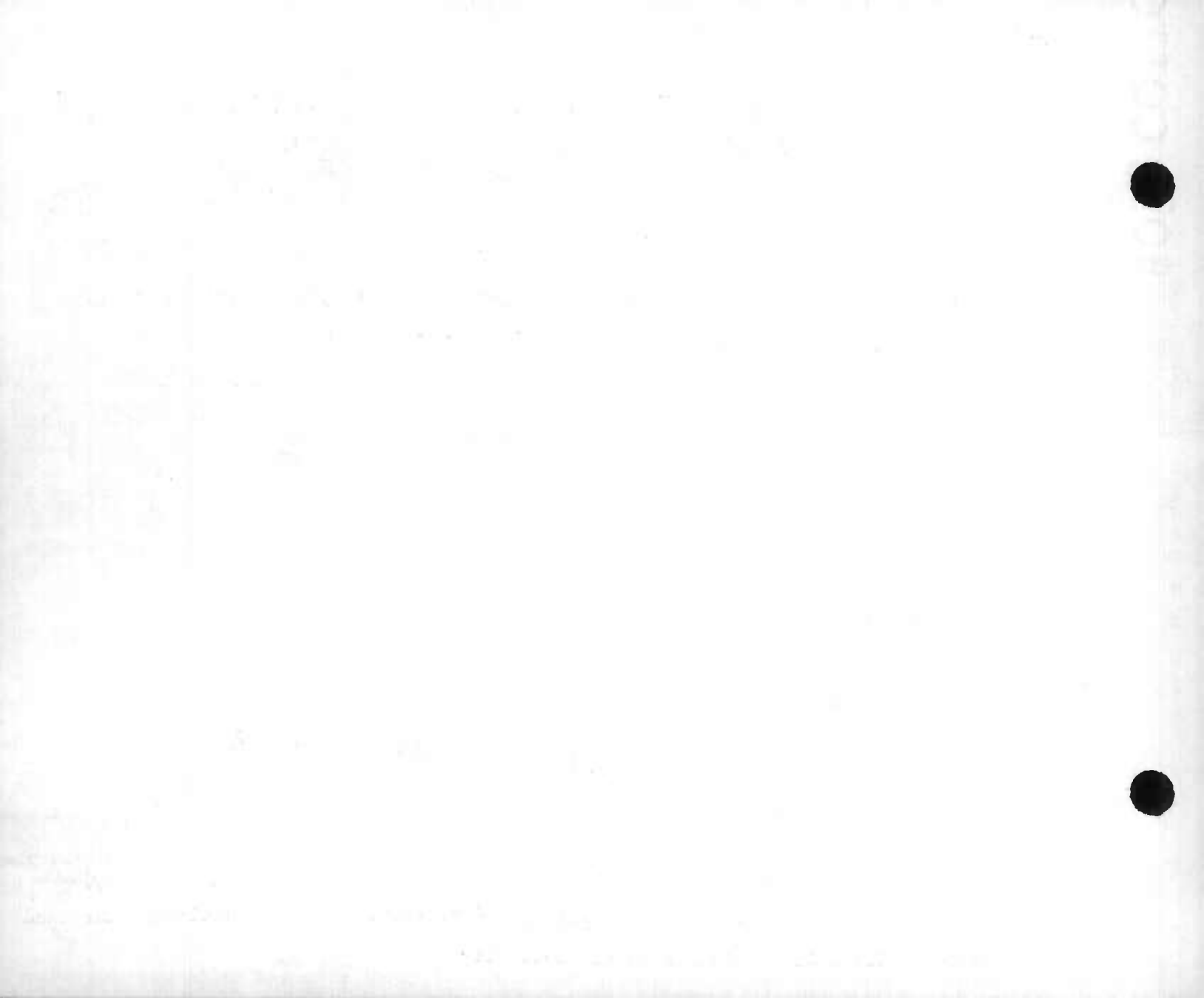
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>N/A</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>10802 Hickory Ridge Rd Columbia MD</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/7</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William Flowers MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/7/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Flowers MD</b>		22e. ADDRESS <b>10802 Hickory Ridge Rd Columbia MD</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 12, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Vets.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry R Witzke 4112 Columbia Rd Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 10 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Jana Harrison</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 days or less after death, the death certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR ADELE EVA LAUKAITIS									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADELE EVA LAUKAITIS						2a. DATE OF DEATH MONTH DAY YEAR 12 30 84		2b. HOUR 5:30 P. M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 6 27 17		6. AGE (IN YEARS LAST BIRTHDAY) 67 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD County MD.			
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9628 BASKET RING ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21045 5791 Stevens Forest Road	
14. FATHER'S NAME FIRST MIDDLE LAST ALPHONSE GOWALLIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA MAJEJKA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 21309 9138		17. INFORMANT ADDRESS Edward T. Laukaitis Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 YRS.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) —					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —					
22a. I certify that (I) (the hospital) attended the deceased from 1978, 19, to 12.30.84, 19, that (I) (last) saw the deceased alive on 12.23.84, 19, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.									
22b. SIGNATURE (NAME OR PRINT) T.A. DAVIDSON JR MD						DEGREE MD		22c. DATE SIGNED 12.30.84	
22d. PHYSICIAN'S NAME (NAME OR PRINT) T.A. DAVIDSON JR MD						22e. ADDRESS 5791 HARPER'S FARM RD COLUMBIA MD 21044			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/2/85		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Md.			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, Md. 21045						25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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7.2.11

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2000-01-01

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH33809  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMILY M MACYS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 6 84</b>		2b. HOUR <b>7:36 P</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 4 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD CTY. GEN. HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private Nurse</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Macys, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Vilkaitis</b>		13e. STREET ADDRESS / ZIP CODE <b>6622 Eberle Dr. Apt. 301 21215</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. <b>215-67-5627A</b>		17. INFORMANT <b>Ralph Macys</b>		ADDRESS <b>5265 Bright Dawn Ct. 21045</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic breast cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If I (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. Michael Joly</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/6/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Michael Joly</b>		22e. ADDRESS <b>Howard County General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/10/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer Cem. Baltimore</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 10 1984</b>		25b. REGISTRAR'S SIGNATURE <i>ma Davidson-Randall</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having been viewed, injury, or other traumatic event, the medical examiner must be notified of such.



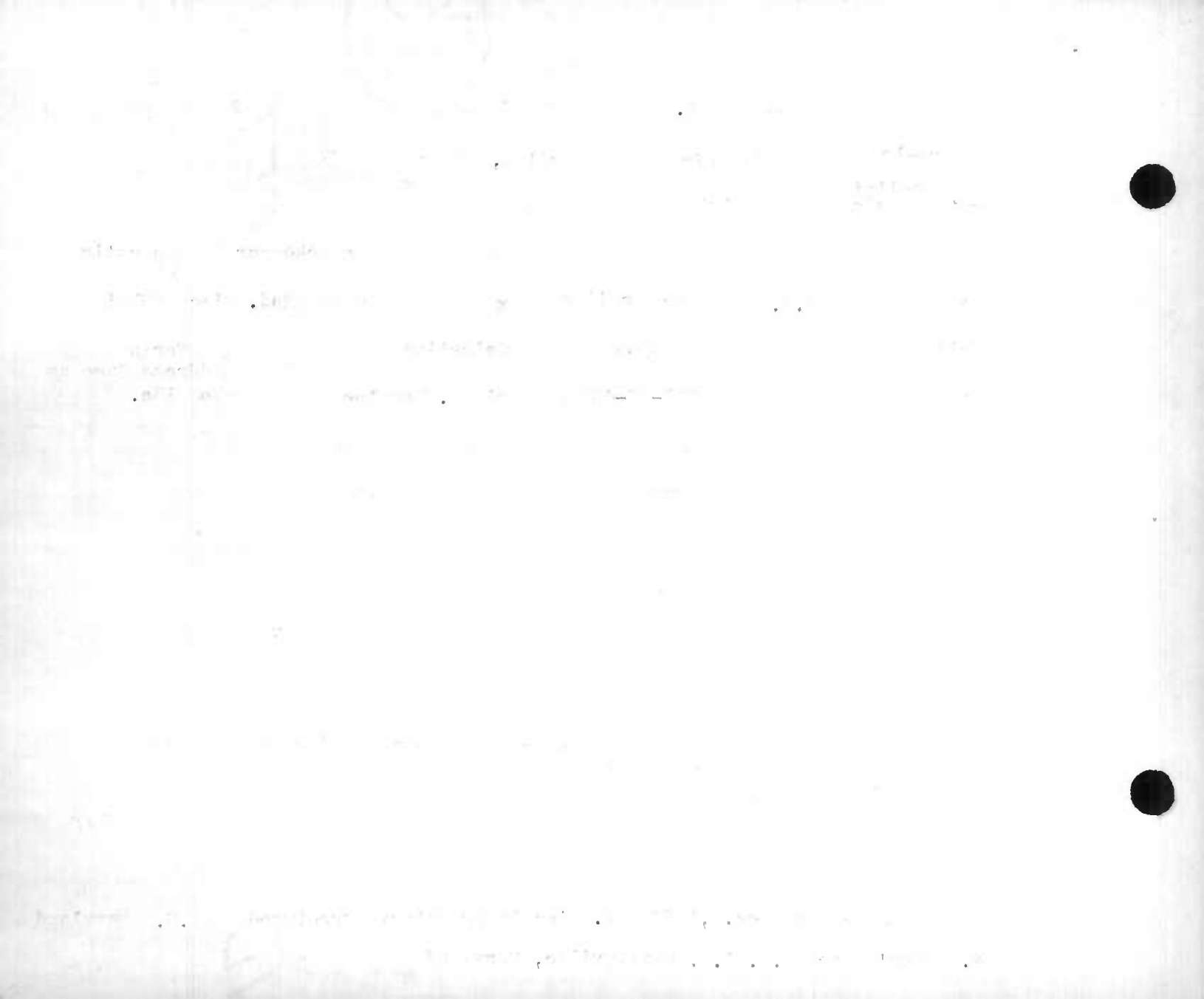
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33810 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>EMILIA T. MANJON</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>12 5 84</b>			2b. HOUR <b>3<sup>10</sup> A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Hispanic</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 5, 1914</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Bolivia South America</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Bolivia</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>P.G.</b> 13c. CITY OR TOWN <b>Hyattsville</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4904 42nd, Place 20781</b>			
FATHER'S NAME FIRST MIDDLE LAST <b>Julio Manjon</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Celestina Teran</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-58-4558</b>			
17. INFORMANT <b>Maria T. Rosales</b>						ADDRESS <b>Address Same as No# 13e.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock - Metabolic Acidosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrest - Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 4</b> , 19 <b>84</b> , to <b>Dec 5</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>Dec 5</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. Garbin</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/5/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Garbin</b>						22e. ADDRESS <b>1109 Spains, SE. S. Love Spains</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>Dec. 7, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>			
24. FUNERAL DIRECTOR <b>F. Garbin's Sons F.H. P.A. Hyattsville, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1984</b>		25b. REGISTRAR'S SIGNATURE <b>J. Garbin</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Vera M. MASTRANGELO				12/22/84				8 <sup>24</sup> PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		3/20/12		72 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
RUSSIA		USA				Howard MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Columbia		Lorien Nursing Home						Housewife		-	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.		Howard		Columbia		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5748 Stevens Forest Rd. 21045			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS			
Late Benjamin Volin				Late Mary				5748 Stevens Forest Rd. Columbia, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
NO		054-30-9833		Mr. John Mastangelo							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Multiple myeloma											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
[Signature]		[Signature]						12/23/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		12-26-84		Mt St Marys		Flushing Queens NY					
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harry H Witzke		4112 Columbia Rd		Ellicott City Md		DEC 28 1984		[Signature]			

BP

DATE 3/ 3

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**3 3 8 1 2**  
REG. NO.

**1- FOR  
STATE  
REGISTRAR**

1. DECEASED NAME (TYPE OR PRINT) <b>Henrietta Means</b>				2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 11/22 19 84				2b. HOUR M 1:20A			
3. SEX <b>F</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR 4-28-29		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY</b>				10. CITY OR TOWN OF DEATH <b>Howard Co.</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt 70 1/2 mile west of Rt 97 junction</b>			
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hoosa Keeping</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>				13. STREET ADDRESS <b>1716 Dodson Ave</b>			
13a. STATE <b>TENN.</b>				13b. COUNTY <b>CHATTANOOGA</b>				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME <b>Henry Simpson</b>				15. MOTHER'S MAIDEN NAME <b>Mary Graham</b>				16. SOCIAL SECURITY NO. <b>409-92-5126</b>			
17. INFORMANT <b>Brady Means</b>				17b. ADDRESS <b>1716 Dodson Ave.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> 8121 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:30AM 11/22/84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Impact</b> <b>Passenger tractor trailer/tractor trailer</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Highway</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt 70 Near Rt 97, Howard Co., MD</b>			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>GR</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>11/22/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>BURIAL</b>				23b. DATE <b>11-27-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HIGHLAND CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CHATTANOOGA TENN</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>JOSEPH L. RUSSELL 21224 NORTH AVE</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>			

**MEDICAL CERTIFICATION**

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE VITAL RECORDS DIVISION AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

999999  
DHMH - 17  
(VR A15 ME (5))



*[Faint handwritten signature or initials]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33813

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELMER L. MOOMAW</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/28/84</b>		2b. HOUR <b>8<sup>55</sup> A.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 23 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCK DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FREIGHT LINES</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALEXANDER MOOMAW</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DOLLY DELLINGER</b>		13e. STREET ADDRESS / ZIP CODE <b>11 N. MORERICK AVENUE, 21228</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-09-3146</b>		17. INFORMANT ADDRESS <b>HELEN G. MOOMAW 11 N. MORERICK AVENUE, 21228</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**BILATERAL PNEUMONIA**Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

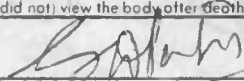
(b) **CORONARY ARTERY DISEASE.**

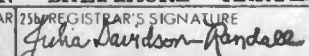
DUE TO, OR AS A CONSEQUENCE OF

(c) **PROSTATIC CARCINOMA.**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

**PARKINSON'S DISEASE, ORGANIC BRAIN SYNDROME, Rt. Intracranial Hematoma**

19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>- - - 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>-</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>- - - - -</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-30-1984</b> to <b>12-28-1984</b> , that (I) (we) last saw the deceased alive on <b>12-28-1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/28/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUDHIR D. PATEL</b>				22e. ADDRESS <b>HOWARD COUNTY GEN. HOSP.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-31-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WOODLAWN BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1984</b>		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 is, notify injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



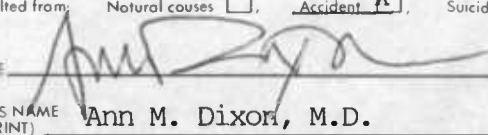

100-100000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 8 1 4

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DENNIS</b>			2. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 16 19 84</b>			2b HOUR <b>10:20 a.m.</b>		
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 8, 1918</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>66</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 16 19 84</b>	7d. HOUR <b>10:20 a.m.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>U.S. Rt. 1</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>
13a. STATE <b>Md.</b>			13b. CITY OR TOWN <b>Pr. Geo.</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>6401 Forest Mill Lane 20707</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dennis Moore, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Watkins</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>212-14-5456</b>		17. INFORMANT ADDRESS <b>Barbara Moore (Wife) same as #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thoracic trauma</b> <b>8150</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9:09** 12-16- 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Driver in auto/fixed object impact.</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>U.S. Rt. 1 Cheltenham, Pr. Geo. Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>12-16-84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-20-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>md. Veterans Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham, Pr. Geo. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Snowden Funeral Home, P.A. Rockville, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 24 1984</b>			
					25b. REGISTRAR'S SIGNATURE 			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

90% COTTON 10% WOOL

WASHABLE



MADE IN U.S.A.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH33815  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Irvine M. Moore			2a. DATE OF DEATH MONTH DAY YEAR 12 11 84		2b. HOUR 1057 PM
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 01 11 21		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp.		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired teacher		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.	13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9017 Watchlight Ct. 21045	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Moore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Glenzie Campbell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 212-14-3355		17. INFORMANT ADDRESS Cordelia Ford 503 Baker St.	
18. CAUSE OF DEATH (Enter only one cause per line, and PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONITIS, ACUTE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PANCREATITIS</u>					
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED OFFICE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-8-</u> 19 <u>84</u> to <u>12-11-</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-11-</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Merchant Deepak		DEGREE MD- ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-12-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deepak Merchant		22e. ADDRESS 3350 Wilkens Ave. Baltimore MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-13-84	23c. NAME OF CEMETERY OR CREMATORY Westview Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME Carlton C. Douglass		ADDRESS 1012 Penn Ave.		25a. DATE REC'D. BY REGISTRAR DEC 14 1984	
				25b. REGISTRAR'S SIGNATURE Lillian Friedman Randall	

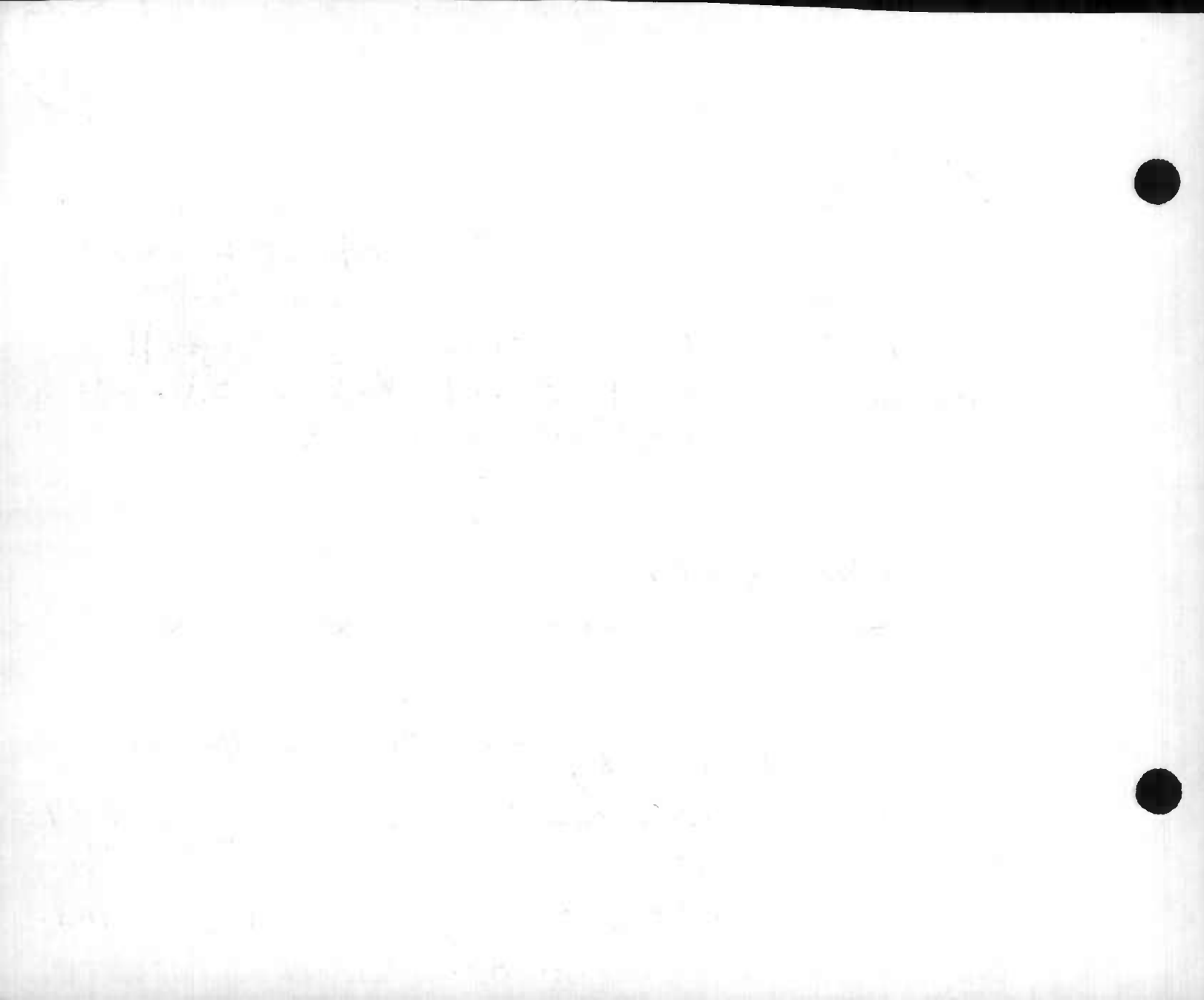
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 3 8 1 6  
REG. NO.

1- FOR  
STATE  
REGISTRAR

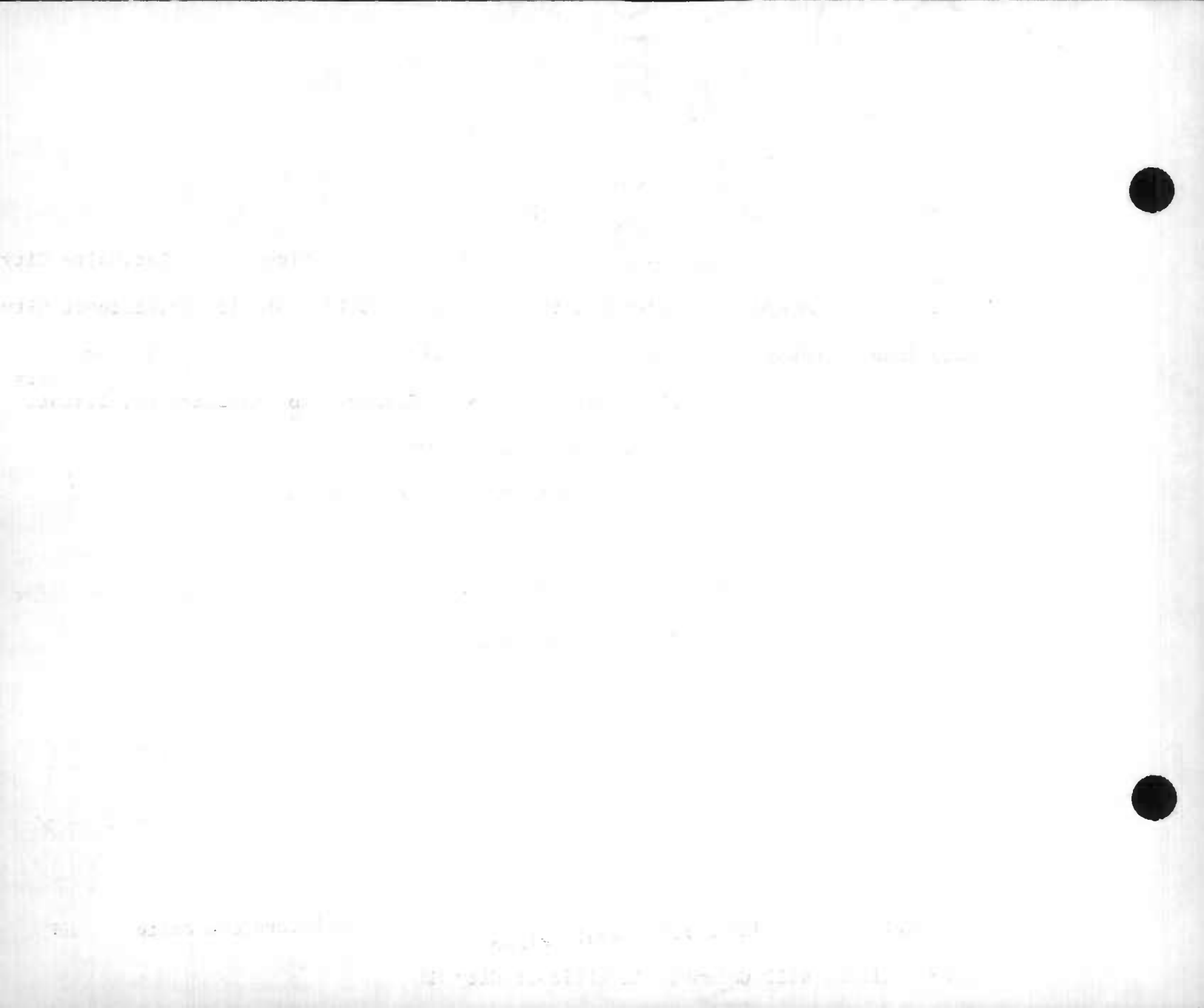
1. DECEASED NAME (TYPE OR PRINT) Clarence E. Morris			2a. DATE OF DEATH MONTH DAY YEAR 12-31-84			2b. HOUR 12 <sup>45</sup> AM			
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 25 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.			
10. CITY OR TOWN OF DEATH Columbia MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Est, Balto City	
13a. STATE Md		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3110 Paulskirk Dr, Ellicott City 21043	
14. FATHER'S NAME FIRST MIDDLE LAST Late John Edward Morris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Late Lilly Vicker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 265-07-9476		17. INFORMANT ADDRESS City William H Garmer 3110 Paulskirk Dr, Ellicott					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) WOUND ABSCESS w/ SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Severe COPD; CAERHERIA 2° INADEQUATE CORAL INTAKE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FEEDING GASTROSTOMY				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/5 19 84 to 12/31 19 84, that (I) (we) last saw the deceased alive on 12/30 19 84, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Lawrence Smith MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-31-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 2 1985		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Reisterstown Balto MD			
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd Ellicott City Md				25a. DATE RECEIVED BY REGISTRAR JAN 4 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Hendell			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Paper always retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

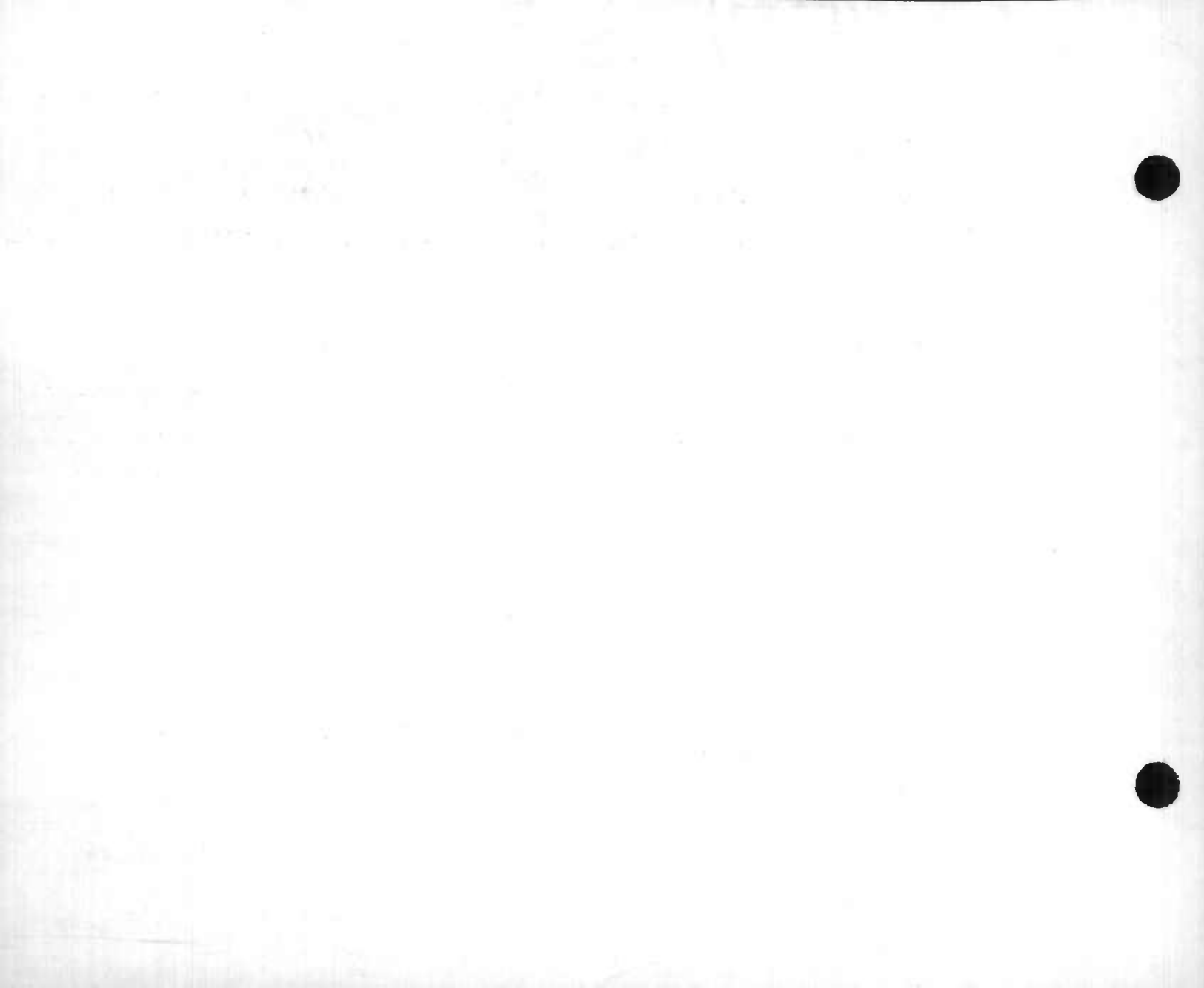
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

33817  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN W. Nock</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-4-84</b>			2b. HOUR <b>5:03 AM</b>					
3. SEX <b>M Male</b>		4. RACE <b>W White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-23-14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE) <b>retired owner</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>ELICOTT CITY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3741 CHATHAM RD / 21043</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Mayhew Nock</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Minnie Byrd</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-10-7851</b>		17. INFORMANT ADDRESS <b>Mrs Doris Nock 3741 Chatham Rd Ellicott City 21043</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>ULCERATIVE COLITIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>WEEKS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>											
19a. DATE OF OPERATION <b>11/17/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>COLITIS, COLESTOMY.</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>10802 Hickory Ridge Rd Columbia, Md.</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 28</b> , 19 <b>84</b> , to <b>12-4</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>12-4</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Jerry L. Levine</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>12/9/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JERRY L. LEVINE, M.D.</b>				22e. ADDRESS <b>10802 Hickory Ridge Rd Columbia, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 7, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke</b>				ADDRESS <b>4112 Columbia Rd Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 10 1984</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified at once.

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH 8 4

REG. NO. 3 3 8 1 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen Theresa Rehmert</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>December 29, 1984</i>			2b. HOUR <i>9:55 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>Cau.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 21 1911</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>IF UNDER 24 HRS.</i>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore City</i>		9. CITIZEN OF WHAT COUNTRY? <i>USA</i>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i> MD.			
12. CITY OR TOWN OF DEATH <i>Columbia</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lorien Nursing home</i>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House wife</i>		15. KIND OF BUSINESS OR INDUSTRY <i>NA</i>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>Howard</i> 13c. CITY OR TOWN <i>Ellicott City</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3521 Font Hill Dr 21043</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Schmidt</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>HELEN ELLSWORTH Adams</i>		16. ADDRESS <i>ELLCOTT CITY, MD.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-07-1546</i>		17. INFORMANT <i>JOHN C. REHMERT</i>		18. ADDRESS <i>3521 FONT HILL DRIVE 21043</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*bilateral cerebrovascular accident*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) *previous myocardial infarction*

DUE TO, OR AS A CONSEQUENCE OF

(c) *atherosclerotic cardiovascular disease*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

*mild congestive heart failure*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>10/8</i> , 19 <i>84</i> , to <i>December 29</i> , 19 <i>84</i> , that (1) (we) lost saw the deceased alive on <i>December 27</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Gregory D McCormack MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>12/29/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GREGORY D MCCORMACK</i>		22e. ADDRESS <i>11085 LITTLE PATUXENT PKWY #101 COLUMBIA MD 21044</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>01-02-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lawson Park Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore MD</i>	
24. FUNERAL DIRECTOR <i>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 31 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 8 4										3 3 8 1 9 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>SOPHIE ANN REWA</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12 27 84</b>		2b. HOUR <b>11 30 P.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 22 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASSACHUSETTS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD</b>					
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5083 LAKE CIRCLE WEST</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PART-TIME</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft supply / T.</b>			
13a. STATE <b>CONNECTICUT</b>		13b. COUNTY <b>HARTFORD</b>		13c. CITY OR TOWN <b>E. HARTFORD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>83 PROSPECT ST. 06108</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ANTHONY KUBERA</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOSEPHINE BOGDANSKI</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES) <b>-</b>			
16b. SOCIAL SECURITY NO. <b>016-12-8482</b>				17. INFORMANT <b>BEVERLY ROSETTA</b>				ADDRESS <b>5083 LAKE CIRCLE WEST COLUMBIA, MD 21044</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PRIMARY CHOLANGIOCARCINOMA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 MOS</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <b>12.5.84</b> , 19____, to <b>12.27.84</b> , 19____, that (I) (we) last saw the deceased alive on <b>12.7.84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>T.A. DADISMAN JR MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12.28.84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T.A. DADISMAN JR MD</b>				22e. ADDRESS <b>5499 HARBERS FARM RD COLUMBIA MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-31-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HARTFIELD HAMPSHIRE MASS.</b>					
24. FUNERAL DIRECTOR NAME <b>SLACK FUNERAL HOME</b>		ADDRESS <b>Box 268 ELICOTT CITY, MD. 21043</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Sia Davidson-Randall</b>					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 33820

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ADA L. SANTHIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/1/84</b>			2b. HOUR <b>150/PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10/22/05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GENERAL HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>MT. AIRY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Emory Spencer</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie W. Ulric</b>			13e. STREET ADDRESS <b>PLEASANT View N. +1 MT. AIRY MARYLAND</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>219284722</b>		17. INFORMANT ADDRESS <b>Jean M. Tunney Reisterstown, Md.</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ Minutes</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) <b>SICK SINUS SYNDROME</b>	
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>I</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) **Sepsis possible endocarditis.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/15 1984</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>11/15 1984</b> to <b>12/1 1984</b> , then (1) (we) lost saw the deceased alive on <b>12/1 1984</b> , and that (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Stephen A. Valentini</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/1/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen A. Valentini</b>		22e. ADDRESS <b>Howard County Gen Hosp</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12/4/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carroll Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hampstead Carroll Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home</b> ADDRESS <b>Reisterstown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1984</b>		25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 8 4										REG. NO. 3 3 8 2 1	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Alice</u> <u>Sara</u> <u>Fian</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>12</u> <u>16</u> <u>84</u>			2b. HOUR <u>11:55am</u>			
1. SEX <u>Female</u>		1. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>6</u> <u>15</u> <u>01</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Turkey</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Howard Co.</u> MD.					
10. CITY OR TOWN OF DEATH <u>Columbia</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Lorien Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>MD</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spr.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>3764 Bel Pre Rd Apt 48</u> <u>20906</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Late Levon Lachiniam</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>late Gulizar Shimshirian</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u>		16b. SOCIAL SECURITY NO. <u>197-18-803D</u>		17. INFORMANT ADDRESS <u>Zavart Jamgochian</u> <u>3764 Bel Pre Rd Silver Sp</u> <u>MD 20906</u>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>chronic renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension, nephrectomy</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>cardiovascular accident</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>9/18</u> 19 <u>84</u> to <u>December 16</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>December 8</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dregory D. McCormack</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/16/84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>McORMACK</u>					22e. ADDRESS <u>11085 Little Patuxent Pkwy #101</u> <u>Columbia Md 21044</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Dec 18, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Montgomery Co. Maryland</u>				
24. FUNERAL DIRECTOR NAME <u>Harry H Witzke</u>					ADDRESS <u>4112 Columbia Rd Ellicott City</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 21 1984</u>				
					25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>						

BP

ALBUQUERQUE, N.M.

TO THE SECRETARY OF THE INTERIOR

FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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[Illegible]





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 3 8 2 2

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 11 1984										2b. HOUR M 11p											
1. DECEASED NAME (TYPE OR PRINT) PHILIP George SCHWAAB III										2c. DATE PRONOUNCED DEAD 12 11 1984										2d. HOUR M 11p											
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3-10-31		6. AGE (IN YEARS) 53 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Education Specialist										12b. KIND OF BUSINESS OR INDUSTRY Maryland									
13a. CITY OR TOWN OF DEATH Woodstock				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Md. Rt. 99 e. of Woodstock Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Education Specialist				12b. KIND OF BUSINESS OR INDUSTRY Maryland				12c. DATE OF DEATH 12-11-84															
13a. STATE Md.				13b. COUNTY Carroll				13c. CITY OR TOWN Sykesville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 1307 Terrace Court 21784															
14. FATHER'S NAME (FIRST MIDDLE LAST) Philip G. Schwaab, Jr.										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Catherine Russell																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES										16b. SOCIAL SECURITY NO. 216 28 3154										17. INFORMANT ADDRESS Mary M. Schwaab Sykesville, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 9:40 P.M. 12-11-1984										21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 9:40 P.M. 12-11-1984										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/fixed object impact.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road										21f. LOCATION STREET CITY OR TOWN COUNTY STATE Md. Rt. 99 e. of Woodstock Rd., Howard, Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																															
ACTUAL SIGNATURE [Signature]										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 12-12-84											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.										ADDRESS 111 Penn St., Balto., Md. 21201																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 12-15-84										23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.	
24. FUNERAL DIRECTOR NAME Harry W. Haight										ADDRESS Sykesville, Md.										25a. DATE REC'D BY REGISTRAR 12-14-84		25b. REGISTRAR'S SIGNATURE [Signature]									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald Leon Severe, Jr.						2a DATE KNOWN OF DEATH XX MONTH DAY YEAR 12 13 1984		2b HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 8 23 56		6 AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 28 YRS.		7c DATE PRONOUNCED DEAD MONTH DAY YEAR 12 13 1984	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD			
10 CITY OR TOWN OF DEATH Elkridge		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6754 Santa Barbara Court				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quality Control		12b KIND OF BUSINESS OR INDUSTRY Chesapeake Finished Metals	
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 3634 Greenvale Rd. 21229	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Mattis				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabell Jenkins					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b SOCIAL SECURITY NO. 214-70-9264		17 INFORMANT ADDRESS Doreen M. Severe 3634 Greenvale Rd. 21229			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8839 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b APPROX. HOUR A.M. MONTH DAY YEAR 1:40PM 12/12 1984		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell into tank after explosion			
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) factory		21f LOCATION CHESAPEAKE FINISHED METALS CORP. 6754 Santa Barbara Court, Elkridge, Howard Co. MD			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquest <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Ann M. Dixon				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12/13/84	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/17/84		23c NAME OF CEMETERY OR CREMATORY Western Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24 FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				25a DATE REC'D. BY REGISTRAR DEC 14 1984		25b REGISTRAR'S SIGNATURE [Signature]			

END OF VOLUME

1- FOR 6/6/95 rja  
 REGISTRAR VERNON L. SMITH

 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

 3 3 8 2 4  
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vernon L. Smith			2a. DATE OF DEATH MONTH DAY YEAR 12 23 84			2b. HOUR 11:50 PM	
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 07 92		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT	
12b. KIND OF BUSINESS OR INDUSTRY B&O RAILROAD		13a. STATE md					
13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8836 Town + Country BL 21043	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM SMITH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA FLYNN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 705-05-3126		17. INFORMANT DOROTHY SMITH 8836 ELLICOTT MD 21043		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia.		10 days
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic cardiovascular disease. Years		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Pneumonitis, Hypoproteinemia, Uremia.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21c. LOCATION STREET CITY OR TOWN COUNTY STATE		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
22a. I certify that (1) this hospital attended the deceased from Nov. 30, 1984, to Nov 23, 1984, that (11) we lost above the deceased alive on Nov 23, 1984, and that in (my) our opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE Chong choon Han		22c. DATE SIGNED Nov 23, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) chong choon HAN		22e. ADDRESS 10798 Hickory Ridge Rd. Columbia, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND 21043	
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOME OF CATONSVILLE 1630 EDMONDSON AVENUE BALTIMORE MARYLAND 21228				25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)



1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE OF MARYLAND CERTIFICATE OF DEATH 8-4				33825 REG. NO.			
1. DECEASED NAME [TYPE OR PRINT] <b>Joseph Spriggs</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12/7/84</b>				2b. HOUR MIN <b>12<sup>49</sup></b>	
3. SEX <b>MALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 01 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lorien N.H.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Henry Spriggs</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Cromwell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>217-16-8721</b>		17. INFORMANT <b>Elmira S. Tilley</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Embolus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Organic brain syndrome</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>organic brain syndrome</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Krishna P. Kumar</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12.7.84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KRISHNA P KUMAR</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/12/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL HOME NAME <b>Funeral Home Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 12 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Edwardson-Randell</b>			
25c. ADDRESS <b>2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>									

From 1 Home Inc.      Harbor & Sons      12/1/1918      Baltimore, Maryland  
 Baltimore, Maryland      12/1/1918      Baltimore, Maryland

Yes      William      Henry      George      Mary      Will      Crossell  
 12/1/1918      12/1/1918      12/1/1918      12/1/1918      12/1/1918      12/1/1918      12/1/1918

12/1/1918      12/1/1918      12/1/1918      12/1/1918      12/1/1918      12/1/1918      12/1/1918

12/1/1918      12/1/1918      12/1/1918      12/1/1918      12/1/1918      12/1/1918      12/1/1918

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		33826 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frank R. Starr</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 16 84</b>		2b. HOUR <b>1520 M</b>
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 15 42</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Florida</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD</b>	
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9825 Rainleaf Ct.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Navy</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Columbia</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Starr</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alma Martin</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea/ Nam 262-62-6947</b>		17. INFORMANT ADDRESS <b>Nancy E. Starr - Same as Sec. 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypercalcemia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Diffuse Histiocytic lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1984</b> to <b>Dec 1984</b> that (I) (we) lost saw the deceased alive on <b>4 Dec 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Pam Sholar, M.D.</b>		DEGREE		22c. DATE SIGNED <b>17 Dec 84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Pam Sholar, M.D.</b>		22e. ADDRESS <b>Naval Hospital Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12-18-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westview Baltimore MD.</b>					
24. FUNERAL DIRECTOR NAME <b>Leta M. &amp; Russell C. Witzke Funeral Homes P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	
25c. ADDRESS <b>5555 Twin Knolls Rd., Columbia, MD. 21045</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>THALASIA THEOLOGOS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12 17 84</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 24 1896</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Adelphi</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>10516 Carnation Ct.</b>		<b>20783</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vasile Venetis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Pauline UNK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>None</b>		16b. SOCIAL SECURITY NO. <b>134 22 1975</b>		17. INFORMANT <b>Son</b> <b>Peter Theologos (Same as 13E)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK, HYPOTENSION.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ENCEPHALOPATHY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GLOBAL HYPOXIA.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 HRS.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>MYOCARDIAL ISCHEMIA</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-14</b> , 19 <b>84</b> , to <b>12-17</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>12-17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Krishna P. Kumar</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KRISHNA P. KUMAR</b>		22e. ADDRESS <b>Howard County Hospital Columbia, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/21/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi PG Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1984</b>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 33828

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth Marie Thompson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 22 84</b>			2b. HOUR <b>3:15 PM</b>					
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 3 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Woodbine</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>15885 Meadow Walk Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Woodbine</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>15885 Meadow Walk Rd. 21676</b>		
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Wilbur D. Graham</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Virginia C. Arbogast</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215149203</b>	
17. INFORMANT ADDRESS <b>15885 Meadow Walk Rd.</b>				17. INFORMANT <b>Edwin J. Thompson, Jr.</b>				17. INFORMANT <b>Woodbine, MD</b>		17. INFORMANT	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Lung Cancer</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/1</b> 19 <b>84</b> to <b>12/22</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>12/10</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. Steven Newman</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/23/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Steven Newman</b>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-24-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marmotsville Howard MD</b>	
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b>				ADDRESS <b>Sykesville, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 24 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

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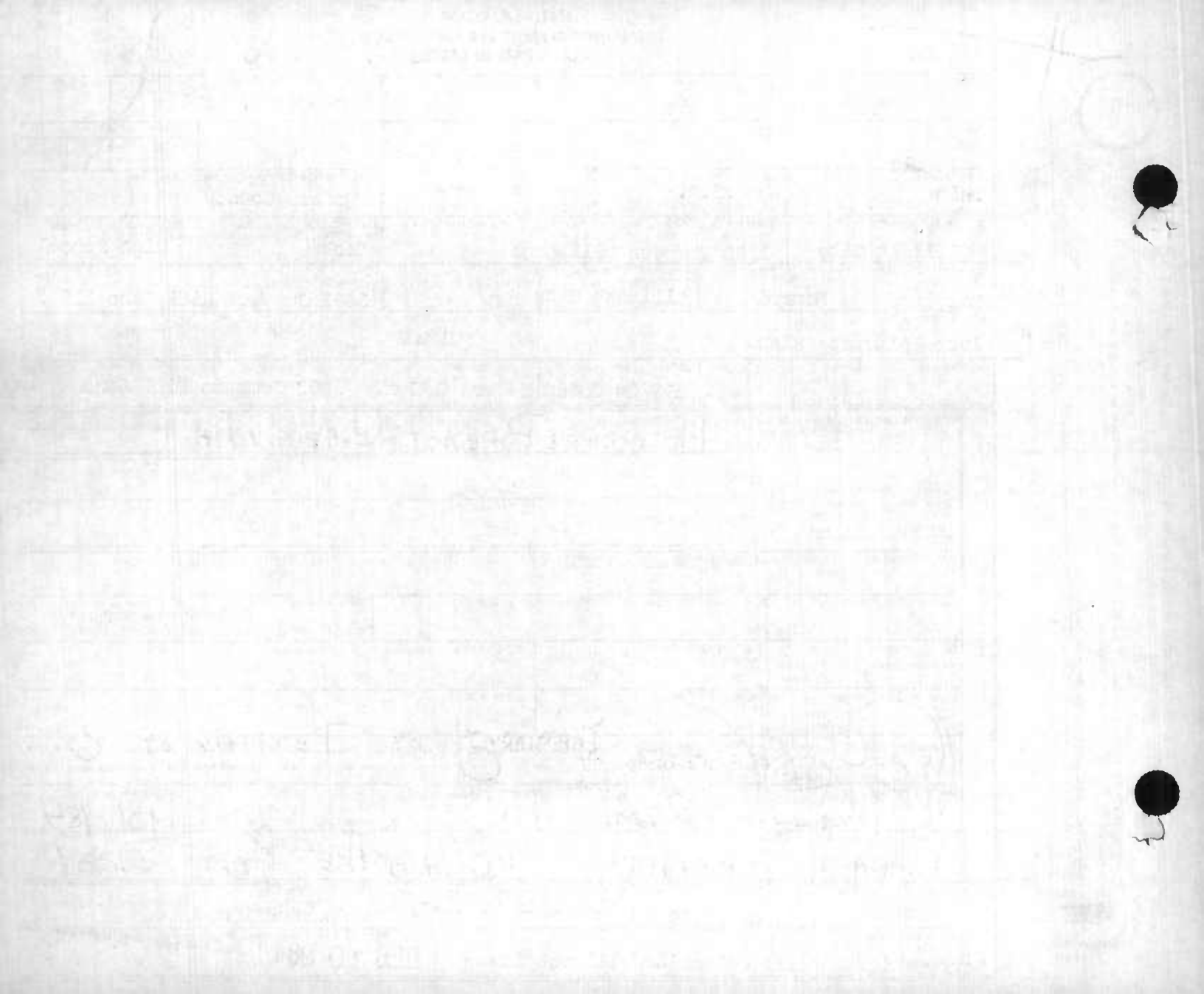
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 33829			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Evelyn Tulia Uhrig				December 6, 1984			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR January 13, 1928		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 56	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10 CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3893 Jumpers Hill Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY High School	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City	
14. FATHER'S NAME FIRST MIDDLE LAST late Alfonso Fisco				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tulia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 277 24 0058		17. INFORMANT ADDRESS Edward O Uhrig 3893 Jumpers Hill Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC BREAST CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN, COUNTY, STATE)			
22. I certify that (1) (this hospital) attended the deceased from <u>FEBRUARY 24</u> 19 <u>84</u> to <u>DECEMBER 6</u> 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>DECEMBER 6</u> 19 <u>84</u> , and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated							
22a. SIGNATURE <u>Diana H. Griffiths</u>		22b. PHYSICIAN'S NAME (TYPE OR PRINT) DIANA H. GRIFFITHS		22c. ADDRESS 900 CATOW AVE. BALT.		22d. DATE SIGNED 12/6/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 10, 1984		23c. NAME OF CEMETERY OR CREMATORY All Souls Cemetery		23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Chardon Ohio	
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd				25a. DATE REC'D. BY REGISTRAR DEC 10 1984			
25b. REGISTRAR'S SIGNATURE <u>Jane Harrison</u>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH		2b. HOUR	
JANYCE L. WAHL						12-1-84		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	Nov. 30, 1948	36 YRS.			12-1-84		12:01P	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Illinois			U.S.A.					Howard County MD	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Columbia			Howard County General Hospital			Housewife		Home	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Howard			Columbia		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS			
John J.			Helen Swiekos			9559 Many Miles Mews 21046			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No			353-40-6571			Bruce Wahl Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1 DEATH WAS CAUSED BY: <u>Acute Amithriptyline Intoxication</u>									
IMMEDIATE CAUSE (a)									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR		Self ingested				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION				
			Home		9559 Many Miles Mews Columbia, Howard Co. Md				
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			
Thomas D. Smith, M.D.			Deputy Chief			12-2-84			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS						
			111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Cremation			12/5/84		Westview Memorial		Catonsville County STATE		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Leroy M. & Russell C. Witzke Funeral Homes P.A.			DEC 4 1984			John Davidson-Randall			
5555 Twin Knolls Road, Columbia, Md. 21045									



RECEIVED  
JAN 11 1968  
U.S. DEPT. OF JUSTICE

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3383

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 3.8 3 1											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		X MONTH DAY YEAR		2b. HOUR	
IVA		MYRTLE		WATSON				12-30-84					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
F		W		Dec 12 1903		81						12-30-84 9:15A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
VIRGINIA		U.S.A.				Howard County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Ellicott City		5471 Montgomery Rd.		Homemaker		Domestic							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
MD		HOWARD		Ellicott City				5471 MONTGOMERY RD 21043					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
BYRON		B.		SHENK		IDA				KIBLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		216-48-9483		RANOLPH Zamzon		Ellicott City MD 21043							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt force injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. DATE YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		12/23/84		subject found beaten									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN									
		unknown		5471 Montgomery Rd. Ellicott City, Maryland									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		M.D.		TITLE (SPECIFY)		DATE		12-31-84					
Margarita A. Korell, M.D.		Assistant		MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
111 Penn S Street													
23a. BURIAL CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		1-4-85		BEANM'S CHAPEL Cem		LURAY		PAGE		VA			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
SLACK FUNERAL HOME		BOX 268 ELICOTT CITY MD 21043		JAN 3 1985		Jana Davidson-Rodell							

20% COLIC

WINTER



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT ALONG WITH PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 8 3 2

1. DECEASED NAME (TYPE OR PRINT)		FIRST Dorothy		MIDDLE C.		LAST WEST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 12-17		DAY 1984		YEAR -		2b. HOUR M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 18 1913		6. AGE IN YEARS (LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 12-17 1984		2d. HOUR 3P5		2e. HOUR M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) R. I.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD											
10. CITY OR TOWN OF DEATH GLENWOOD		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3317 BRANTLEY RD. GLENWOOD, MD		12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC											
13a. STATE MD		13b. CITY OR TOWN HOWARD		13c. CITY OR TOWN GLENWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21738 3317 BRANTLEY RD GLENWOOD, MD.									
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES CARPENTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETTA FORD															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 035/09/1187		17. INFORMANT ROGER WEST		ADDRESS MD. 21738 3317 BRANTLEY RD. GLENWOOD											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive-arteriosclerotic cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE Thomas F. Herbert		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER												DATE SIGNED 12-17-84	
EXAMINER'S NAME (TYPE OR PRINT) Thomas F. Herbert, MD		ADDRESS Ellicott City, Md 21043															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/20/84		23c. NAME OF CEMETERY OR CREMATORY HIGHLAND MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE JOHNSTON PROVIDENCE R. I.											
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS BOX 268 ELLICOTT CITY, MD 21043		25a. DATE REC'D. BY REGISTRAR DEC 21 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall											



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